VII. HOSPITALS UNDER MEDICAID RETROSPECTIVE COST REIMBURSEMENT (CRITICAL ACCESS HOSPITALS)

A few Nevada hospitals have been designated by Medicare as Critical Access Hospitals.

To the extent these hospitals participate in Medicaid, they are reimbursed under Medicare's retrospective cost reimbursement, as follows:

A. Inpatient hospital services which have been certified for payment at the acute level by the QIO-like vendor, as specified in the contract between the QIO-like vendor and Nevada Medicaid, upon final settlement are reimbursed allowable costs under hospital-specific retrospective Medicare principles of reimbursement in accordance with 42 CFR Part 413.30 and 413.40, Subpart C, and further described in CMS Publications 15-I and 15-II.

B. On an interim basis, each hospital is paid for certified acute care at the lower of 1) billed charges, or 2) the rate paid to general acute care hospitals for the same services.

Facilities accredited as Residential Treatment Centers by the Joint Commission on Accreditation of Health Organization (JCAHO) are not considered specialty or general acute hospitals. Residential Treatment Centers are paid in accordance with paragraph VI above.

VIII. HOSPITALS SERVING LOW-INCOME PATIENTS
DISPROPORTIONATE SHARE HOSPITALS

A. Subject to the provisions of subparagraph 6, a hospital will qualify as disproportionate if it meets any of the conditions under subparagraphs 1 through 5.

1. A hospital's Medicaid inpatient utilization rate is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payment in the State.

2. The hospitals low income utilization is at least 25%. Low income utilization is the sum (expressed as a percentage) of the fractions, calculated as follows:

   a) Total Medicaid patient revenues paid to the hospital, plus the amount of the cash subsidies for patient service received directly from State and local governments in the cost reporting period, divided by the total amount of revenues of the hospital for patient services (including the amount of such cash subsidies) in the same cost reporting period; and,

   b) The total amount of the hospital's charges for inpatient hospital services attributable to charity care (care provided to individuals who have no source of payment, third-party or personal resources) in a cost reporting period, less the portion of any cash subsidies received directly from the state or local government, divided by the total amount of hospital charges for inpatient services in the hospital in the same period. The total inpatient hospital charges attributed to charity care shall not include contractual allowances and discounts (other than for indigent patients not eligible for Medicaid assistance under an approved Medicaid State plan), that is, reductions in charges given to other third party payors, such as HMOs, Medicare, or Blue Cross Blue Shield.

3. For public hospitals (i.e., hospitals owned or operated by a hospital district, county or other unit of local government), the hospital's Medicaid inpatient utilization rate is at least one percent.

4. For counties which do not have a public hospital, the hospital in the county which provided the greatest number of Medicaid inpatient days in the previous year.

5. A private hospital located in a county with a public hospital that has a Medicaid utilization rate greater than the average for all the hospitals receiving Medicaid payment in the State.

6. A hospital must:

   a.) have a Medicaid inpatient utilization rate not less than one percent,

b.) have at least two (2) obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under State Medicaid plan. In the case of a hospital located in a rural area (that is, an area outside of a Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget) the term "obstetrician" include any physician with staff privileges at the hospital to perform non-emergency obstetric procedure. This does not apply to a hospital in which:

i.) The inpatients are predominantly individuals under 18 years of age; or

ii) Does not offer non-emergency obstetric services as of December 21, 1987.

c.) not be an institution for mental disease or other mental health facility subject to the limitation on DSH expenditures under Section 4721 of the Balanced Budget Act of 1997.

7. Medicaid utilization rate means the total number of days of treatment of Medicaid patients, including patients who receive their Medicaid benefits through a health maintenance organization, divided by the total number of days of treatment of all patients during a fiscal year.

B. Distribution Pools: Hospitals qualified under paragraph 'A' above will be grouped into distribution pools on the following basis:

1. Assuming total available DSH in a given fiscal year of $76,000,000, distribution pools are established as follows:

a) All public hospitals qualifying under paragraph A above and in counties whose population is 400,000 or more, the total annual disproportionate share payments are $66,650,000 plus 90% of the total amount distributed by the DHCFP in that fiscal year that exceeds $76,0000.

b) All private hospitals qualifying under paragraph A above and in counties whose population is 400,000 or more, the total annual disproportionate share payments are $1,200,000 plus 2.5% of the total amount distributed by the DHCFP in that fiscal year that exceeds $76,0000.

c) All private hospitals qualifying under paragraph A above and in counties whose population is 100,000 or more but less than 400,000, the total annual disproportionate share payments are $4,800,000 plus 2.5% of the total amount distributed by the DHCFP in that fiscal year that exceeds $76,0000.

d) All public hospitals qualifying under paragraph A above and in counties whose population is less than 100,000, the total annual disproportionate share payments are $900,000 plus 2.5% of the total amount distributed by the DHCFP in that fiscal year that exceeds $76,0000.

e) All private hospitals qualifying under paragraph A above and in counties whose population is less than 100,000, the total annual disproportionate share payments are $2,450,000 plus 2.5% of the total amount distributed by the DHCFP in that fiscal year that exceeds $76,0000.

2. In no circumstances may the total amount of distributions to hospitals within distribution pools noted in 1. above exceed the total uncompensated costs for those facilities.

3. Uncompensated costs are determined by the sum of the cost for providing services to inpatient and outpatient Medicaid and uninsured patients less Medicaid payments (excluding disproportionate share payments) and any patient paid or third party paid amounts. (Third party amounts exclude any payments made by a State or locality to a hospital for services provided to indigent patients.) An "uninsured patient" is defined as an individual for whom services received by the patient are not covered by insurance, whether this coverage is medical or liability based coverage. Patient paid and third party paid amounts are based on the historical collection experience of the hospital for uninsured accounts or actual collections in the fiscal year, whichever is greater. A system must be maintained by the hospitals to match revenues on Medicaid and uninsured patient accounts to the actual billed charges of the accounts in the same fiscal year. Costs for Medicaid and uninsured patients will be based upon the methodology used for a HCFA 2552 report Revenue will be deducted from cost. The total costs on the report will be subject to an independent audit, which must be submitted within six months of the hospital's fiscal year end.